



The Commonwealth of Massachusetts  
**Division of Professional Licensure**

Board of Registration of  
**Speech-Language Pathology and Audiology**  
239 Causeway Street, Boston MA 02114  
(617) 727-3071

**SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY ASSISTANTS  
EVIDENCE OF EMPLOYMENT FORM**

Applicant Name: \_\_\_\_\_

Last

First

Middle

Address: \_\_\_\_\_

No.

Street

Apt. #

City/Town

State

Zip Code

Telephone #: \_\_\_\_\_

I, \_\_\_\_\_ hereby attest that \_\_\_\_\_ has been employed as a  
*Supervisor* *Applicant's Name*

**Speech-Language Pathology /Audiology Assistant at** \_\_\_\_\_  
*Circle One* *Place of Employment*

located \_\_\_\_\_  
*Address* *City* *State* *Zip Code* *Phone #*

from \_\_\_\_\_ to \_\_\_\_\_ for an average of \_\_\_\_\_ per \_\_\_\_\_ totaling  
*month/day/year* *month/day/year* *Hours* *month/week/day*

at least 200 hours in an 18 month period and is professionally competent as an Assistant.

\_\_\_\_\_  
*Signature of Supervisor* *Title* *Date: month / day / year*

\_\_\_\_\_  
*Signature of Notary Public* *Date Notary's Commission Expires: month / day / year*

NOTARY SEAL